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INTRODUCTION

Introduction to the Special Section on Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Disparities: Where We Are and Where We're Going

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It is our privilege to publish this Special Section of six empirical articles that address several key mechanisms for Lesbian, Gay, Bisexual, and Transgender (LGBT) health disparities. Over the past decade, we have seen attention devoted to gender disparities [1, 2], racial/ethnic disparities [3–11], and SES disparities [12–14]. Far fewer articles address the mental or physical health of LGBT individuals, the mechanisms for disparities, or the factors related to within-group differences among LGBT individuals. This relative lack of attention to LGBT individuals helped to motivate a call for such research from the Institute of Medicine [15].

There are currently about 9 million self-identified LGBT adults in the USA [16] (3.8 % of the US population), and a higher percentage report engaging in same-sex sexual behavior (about 4–6 % of men and 11–12 % of women) [17]. Physical health and mental health are often worse for LGBT individuals than for those of heterosexual sexual orientation [18]. According to the minority stress theory [18–20], which is used as a basis for the majority of papers in this Special Section, these health disparities are hypothesized to stem primarily from societal stigma that devalues minority sexual orientation. Manifestations of such societal stigma are at multiple levels, including the national and state policy level (e.g., laws prohibiting same-sex sexual behavior; anti-LGBT marriage laws; lack of laws protecting LGBT individuals from hiring and housing discrimination), the community level (e.g., anti-LGBT interpretation of religious doctrines in faith-based services), and the interpersonal level (e.g., families ostracizing gay youth and withdrawing support; hate crimes against LGBT individuals). In addition to direct experiences with discrimination (i.e., enacted stigma), societal stigma can lead LGBT individuals to experience internalized stigma, in which they personally accept the societal/cultural stigma, as well as to anticipate experiencing stigma from others in the future [21, 22]. All three types of stigma (enacted, internalized, and anticipated) have been shown to have a chilling effect on mental and physical health, and health behaviors among LGBT as well as other populations [23].

Much of what we know about LGBT health is narrowly focused on HIV prevention and treatment, and nearly all of this research has examined gay-identified or non-gay-identified men who have sex with men. From this research, we have learned about contextual and psychosocial disease factors leading to worse health across the HIV cascade [24], from diagnosis to survival, including factors that affect risky health behaviors (such as substance use and sexual risk), the decision to get tested for HIV, poor healthcare utilization, and low adherence to treatment. For example, we know that a large proportion of unprotected sex occurs within the context of a primary relationship among same-sex male couples [25–27]. As a consequence, however, this research has

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overshadowed other LGBT research and led to a conceptualization of LGBT health that is focused on risk and disease.

In contrast, the articles in this Special Section address a wide variety of research questions spanning the domains of health promotion, disease prevention, and access to care. All of the papers examine potential mediating and moderating factors for disparities, rather than only presenting between-group differences (i.e., overall differences in health outcomes between LGBT vs. heterosexual individuals). Some of the papers bring in the concept of resilience for a strength-based (versus disease-based) approach to overcome disparities. Only one paper in the Special Section focuses on people living with HIV [28], and rather than focusing on traditional variables such as condom use and gay men, this paper uses qualitative methods to explore healthcare access issues in an understudied population—transgender individuals.

Most of the studies in the Special Section (and most behavioral medicine research) focus on participants' personal, individual-level characteristics as predictors of health outcomes. However, most of the phenomena under study are a consequence of the broader social context, including families, peer relationships, religious beliefs, and policies that may bracket behavior and define what is acceptable. A good example is found in the article by Calzo et al. [29], which presents a study of the barriers that sexual orientation and gender nonconformity can pose to middle and high school students' physical activity. If a gender nonconforming child is never encouraged by a physical education teacher, sports coach, or family member, it is unlikely that the youth will participate and enjoy team sports. LGBT youth, particularly those who do not conform to "traditional" gender roles, may experience homonegativity in team sports [30, 31]. This cannot be "blamed" on gender nonconformity, self-esteem, athletic ability, or any other aspect of the individual. Instead, it must be seen as a complex problem with causes and ramifications at multiple levels of analysis.

Another Special Section article, by McGarrity and Huebner [32], examines the contextual issue of intersecting identities that shape LGBT individuals' health [33]. The concept of intersectionality takes into account the effects of co-occurring stigmatized identities such as those related to, for example, minority race/ethnicity and low socio-economic status, in addition to sexual minority status [23, 34, 35]. A small amount of research suggests that assessments of stigma from co-occurring identities may yield more comprehensive results about health outcomes than assessment of stigma from any one identity [36–38]. However, research has not yet fully determined the ways in which these identities combine to lead to worse health outcomes; nor have standard statistical methods been developed to examine intersectionality's effects.

Two papers in this Special Section examine contextual factors related to oppressive, discriminatory policies. Hatzenbuehler and colleagues examine how variations in stigmatizing environments, including state-level anti-discriminatory policies, may have an impact on physiological responses to stress [39] as well as tobacco use [40]. This research and that of others underscores the need to remove and intervene against discriminatory policies and practices at multiple levels. These include interpersonal discrimination (e.g., within one's social network), discrimination in healthcare, and within the patient–physician relationship [36, 37, 41], state and federal laws, and international policies. For example, a recent United Nations report found that at least 76 countries have discriminatory laws against same-sex sexual behavior [42]. As shown by the papers in this Special Section [28, 39, 40], discriminatory policies and practices not only may have direct effects on stress responses, and physical and mental health, but also deter LGBT individuals from seeking healthcare and other services in which they fear their sexual minority status may be revealed. Future research could examine the effects of policies at the municipality level, including the damaging health effects of law enforcement practices (that may not be written into law). For example, in several municipalities in the USA, existing policies allow police to use possession of condoms as evidence that a person is involved in sex work; as a result, many sex workers, particularly those who are transgender, have decided not to carry condoms—increasing their risk for HIV and other sexually transmitted infections [43, 44]. When a policy has such clear and drastic implications for the public health, research is needed to document poor health effects to provide a basis for policy change. Based on research showing the harmful effects of the policy, several states, including CA and NY, currently have bills under consideration that would ban such law enforcement practices.

The most understudied area in LGBT health is intervention development and testing; most research, including the studies described in the Special Section, has focused on documenting health disparities and has started to describe reasons for disparities—necessary prerequisites for intervention development. Based on the themes highlighted here, as well as in the Special Section papers, interventions are needed to counteract all aspects of stigma at the societal, community, healthcare, school, and interpersonal levels. For example, as suggested by the research by Calzo and colleagues [29], at the school level, district bullying policies should call attention to not only bullying in general, but also to bullying based on stigmatized characteristics, including LGBT identity, that may lead to worse health and restrict health behaviors (such as physical activity). LGBT youth are more likely to be bullied than non-LGBT youth, and those who are bullied due to sexual minority status versus other characteristics are more likely to experience worse health effects as a result of bullying [45–48]. Research is needed to drive change, to include sexual minority status in state and school anti-bullying policies, and to

develop effective LGBT-focused anti-bullying interventions. Moreover, although the primary target of interventions should ultimately be societal change, interpersonal- and individual-level interventions are also needed for LGBT individuals to build resilience to stigma and strengthen coping with bullying and discrimination.

A final note is that the Special Section does not include articles focused solely on mental health outcomes because studies with an exclusive focus on mental health do not fall under the purview of the journal. Less research has been conducted to understand LGBT physical health disparities than mental health disparities [18], and mental health disparities have been relatively well-documented. For example, although disparities exist for all LGBT categories, research consistently has found high rates of depression and suicidality among youth and victimization among men who have sex with men [15, 49]. Moreover, the body of work on minority stress [20, 50] has largely focused on reasons for mental health disparities. The purpose of this Special Section is to elucidate reasons for physical health disparities, examining mental health as a factor (but not the primary variable of interest). In fact, many current stress theories conceptualize psychological stress responses—of which sexual minority stress is a part—as a precursor to declines in immune, cardiovascular, and endocrine systems [51], and three articles in the Special Section provide support for the physiological impact of minority stress [39, 40, 52]. Given the great deal of valuable and significant research being conducted to advance the field of LGBT mental health disparities, we encourage other relevant higher tier journals to support the publication of such papers as a complement to the articles in this issue.

In conclusion, the articles in this Special Section move us forward toward understanding LGBT health disparities. We hope that the articles stimulate researchers' thinking and compel the conduct of research that does not simply document disparities, but investigates the reasons for their existence at multiple levels of analysis.

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References

1. Naqvi TZ, Naqvi SS, Merz CN. Gender differences in the link between depression and cardiovascular disease. *Psychosom Med*. 2005; 67: S15-S18.
2. Travis CB. Heart disease and gender inequity. *Psychol Women Q*. 2005; 29: 15-23.
3. Whitfield KE, Bogart LM, Revenson TA, France CR. Introduction to special section on health disparities. *Ann Behav Med*. 2012; 43: 1-3.
4. Whitfield KE, Bogart LM, Revenson TA, France CR. Introduction to the second special section on health disparities. *Ann Behav Med*. 2013; 45: 1-2.
5. Brondolo E, Hausmann LR, Jhalani J, et al. Dimensions of perceived racism and self-reported health: Examination of racial/ethnic differences and potential mediators. *Ann Behav Med*. 2011; 42: 14-28.
6. Brondolo E, Lackey S, Love E. Race and health: Racial disparities in hypertension and links between racism and health. In: Baum A, Revension TA, Singer JE, eds. *Handbook of Health Psychology*. 2nd ed. New York, NY: Psychology Press; 2012: 569-594.
7. Echeverria SE, Pentakota SR, Abraido-Lanza AF, et al. Clashing paradigms: An empirical examination of cultural proxies and socioeconomic condition shaping Latino health. *Ann Epidemiol*. 2013; 23: 608-613.
8. Mays VM, Cochran SD, Barnes NW. Race, race-based discrimination, and health outcomes among African Americans. *Annu Rev Psychol*. 2007; 58: 201-225.
9. Ruiz JM, Steffen P, Smith TB. Hispanic mortality paradox: A systematic review and meta-analysis of the longitudinal literature. *Am J Public Health*. 2013; 103: e52-e60.
10. Williams DR, Mohammed SA. Discrimination and racial disparities in health: Evidence and needed research. *J Behav Med*. 2009; 32: 20-47.
11. Brondolo E, Gallo LC, Myers HF. Race, racism and health: Disparities, mechanisms, and interventions. *J Behav Med*. 2009; 32: 1-8.
12. Adler NE, Rehkopf DH. U.S. disparities in health: Descriptions, causes, and mechanisms. *Annu Rev Public Health*. 2008; 29: 235-252.
13. Adler NE. Health disparities through a psychological lens. *Am Psychol*. 2009; 64: 663-673.
14. Ruiz JM, Prather CC, Steffen P. Socioeconomic status and health. In: Baum A, Revension TA, Singer JE, eds. *Handbook of Health Psychology*. 2nd ed. New York, NY: Psychology Press; 2012: 539-568.
15. Institute of Medicine. The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. Washington, DC; 2011.
16. Gates GT. How many people are lesbian, gay, bisexual, and transgender? Available at http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf. Accessibility verified November 5, 2013.
17. Chandra A, Mosher WD, Copen C, Sionean C. Sexual behavior, sexual attraction, and sexual identity in the United States: Data from the 2006-2008 National Survey of Family Growth. National Health Statistics Reports. Number 36. Available at http://www.cdc.gov/nchs/data/nhsr/nhsr036.pdf. Accessibility verified November 5, 2013.
18. Lick DJ, Durso LE, Johnson KL. Minority stress and physical health among sexual minorities. *Perspect Psychol Sci*. 2013; 8: 521-548.
19. Meyer IH. Minority stress and mental health in gay men. *J Health Soc Behav*. 1995; 36: 38-56.
20. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychol Bull*. 2003; 129: 674-697.
21. Earnshaw VA, Chaudoir SR. From conceptualizing to measuring HIV stigma: A review of HIV stigma mechanism measures. *AIDS Behav*. 2009; 13: 1160-1177.
22. Earnshaw VA, Quinn DM, Kalichman SC, Park CL. Development and psychometric evaluation of the Chronic Illness Anticipated Stigma Scale. *J Behav Med*. 2013; 36: 270-282.
23. Earnshaw V, Bogart LM, Dovidio J, Williams D. Stigma and racial/ethnic HIV disparities: Moving towards resilience. *Am Psychol*. 2013; 68: 225-236.
24. Hall HI, Frazier EL, Rhodes P, et al. Differences in human immunodeficiency virus care and treatment among subpopulations in the United States. *JAMA Intern Med*. 2013; 173: 1337-1344.
25. Hoff CC, Beougher SC, Chakravarty D, Darbes LA, Neilands TB. Relationship characteristics and motivations behind agreements among gay male couples: Differences by agreement type and couple serostatus. *AIDS Care*. 2010; 22: 827-835.

26. Prestage G, Jin F, Zablotska I, et al. Trends in agreements between regular partners among gay men in Sydney, Melbourne and Brisbane, Australia. *AIDS Behav*. 2008; 12: 513-520.
27. Mitchell JW, Harvey SM, Champeau D, Seal DW. Relationship factors associated with HIV risk among a sample of gay male couples. *AIDS Behav*. 2012; 16: 404-411.
28. Sevelius JM, Patouhas E, Keatley JG, Johnson MO. Barriers and facilitators to engagement and retention in care among transgender women living with human immunodeficiency virus. *Ann Behav Med.* 2014. doi:10.1007/s12160-013-9565-8.
29. Calzo J, Roberts AL, Corliss HL, Blood EA, Kroshus E, Austin SB. Physical activity in heterosexual and sexual minority adolescents: roles of childhood gender nonconformity and athletic self-esteem. *Ann Behav Med.* 2014. doi:10.1007/s12160-013-9570-y.
30. Roper EA, Halloran E. Attitudes toward gay men and lesbians among heterosexual male and female student-athletes. *Sex Roles*. 2007; 57: 919-928.
31. Southall RM, Nagel MS, Anderson E, Polite FG, Southall C. An investigation of male college athletes' attitudes toward sexual-orientation. *J Issues Intercollegiate Athletics.* 2009;Special Issue: 62-77.
32. McGarrity L, Huebner D. Expanding the study of physical health disparities: sexual orientation outness and the role of socioeconomic status. *Ann Behav Med.* 2014. doi:10.1007/s12160-013-9575-6.
33. Mays VM, Maas RM, Ricks J, Cochran SD. HIV and African-American women in the U.S. South: A social determinants approach to population-level HIV prevention and intervention efforts. In: Baum A, Revension TA, Singer JE, eds. *Handbook of Health Psychology*. 2nd ed. New York, NY: Psychology Press; 2012: 771-801.
34. Cole ER. Intersectionality and research in psychology. *Am Psychol*. 2009; 64: 170-180.
35. Bowleg L. The problem with the phrase women and minorities: Intersectionality—an important theoretical framework for public health. *Am J Public Health*. 2012; 102: 1267-1273.
36. Bogart LM, Wagner GJ, Galvan FH, Klein DJ. Longitudinal relationships between antiretroviral treatment adherence and discrimination due to HIV-serostatus, race, and sexual orientation among African-American men with HIV. *Ann Behav Med*. 2010; 40: 184-190.
37. Bogart LM, Landrine H, Galvan FH, Wagner G, Mizuno L, Klein DJ. Perceived discrimination and physical health among HIV-positive Black and Latino men who have sex with men. *AIDS Behav*. 2013; 17: 1431-1441.
38. Bogart LM, Wagner GJ, Galvan FH, Landrine H, Klein DJ, Sticklor LA. Perceived discrimination and mental health symptoms among Black men with HIV. *Cultur Divers Ethnic Minor Psychol*. 2011; 17: 295-302.
39. Hatzenbuehler ML, McLaughlin KA. Structural stigma and hypothalamic-pituitary-adrenocortical axis reactivity in lesbian, gay, and bisexual young adults. *Ann Behav Med*. 2014. doi:10.1007/s12160-013-9556-9.
40. Hatzenbuehler ML, Jun HJ, Corliss HL, Austin SB. Structural stigma and cigarette smoking in a prospective cohort study of sexual minority and heterosexual youth. *Ann Behav Med*. 2014. doi:10.1007/s12160-013-9548-9.
41. Bird ST, Bogart LM, Delahanty DL. Health-related correlates of perceived discrimination in HIV care. *AIDS Patient Care STDS*. 2004; 18: 19-26.
42. United Nations General Assembly. Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity. Available at http://www2.ohchr.org/english/bodies/hrcouncil/docs/19session/A.HRC.19.41_English.pdf. Accessibility verified November 5, 2013.
43. Human Rights Watch. Sex workers at risk: Condoms as evidence of prostitution in four U.S. cities. Available at http://www.hrw.org/reports/2012/07/19/sex-workers-risk. Accessibility verified November 5, 2013.
44. Woods JB, Galvan FH, Bazargan M, Herman JL, Chen Y. Latina transgender women's interactions with law enforcement in Los Angeles County. *Policing*. 2013; 7: 379-391.
45. Russell ST, Sinclair KO, Poteat VP, Koenig BW. Adolescent health and harassment based on discriminatory bias. *Am J Public Health*. 2012; 102: 493-495.
46. Swearer SM, Turner RK, Givens JE, Pollack WS. 'You're so gay!': Do different forms of bullying matter for adolescent males? *Sch Psych Rev*. 2008; 37: 160-173.
47. Patrick DL, Bell JF, Huang JY, Lazarakis NC, Edwards TC. Bullying and quality of life in youths perceived as gay, lesbian, or bisexual in Washington State, 2010. *Am J Public Health*. 2013; 103: 1255-1261.
48. Robinson JP, Espelage DL, Rivers I. Developmental trends in peer victimization and emotional distress in LGB and heterosexual youth. *Pediatrics*. 2013; 131: 423-430.
49. Saewyc EM. Research on adolescent sexual orientation: Development, health disparities, stigma, and resilience. *J Res Adolesc*. 2011; 21: 256-272.
50. Meyer IH. Prejudice and discrimination as social stressors. In: Meyer IH, Northridge ME, eds. *The Health of Sexual Minorities*. Washington, DC: APA; 2007: 242-267.
51. Hatzenbuehler ML. How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychol Bull*. 2009; 135: 707-730.
52. Everett B, Rosario M, McLaughlin KA, Austin SB. Sexual orientation and gender differences in markers of inflammation and immune functioning. *Ann Behav Med.* 2014. doi:10.1007/s12160-013-9567-6.

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